DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/15/17 70th 5/10/17

PRINTED: 03/01/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445228	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GREENEVILLE	725 CRUM STREET GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A life safety survey was conducted by the state of Tennessee Department of Health, Division of health licensure and regulation office of health care facilities on 2/27/17. During this life safety survey, Life Care Center Greeneville was not found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life safety from fire, and the related National Fire Protection Association (NFPA) standard 101 - 2012 edition.	K 000	Life Care Center of Greeneville is committed to upholding the highest standard of care for its residents. This includes substantial compliance with all applicable standards and regulatory requirements. The facility respectfully works in cooperation with the State of Tennessee Department of Health toward the best interest of those who require the services we provide. While this Plan of Correction is not to be considered an admission of validity of any findings, it is submitted in good faith as a required response to the survey conducted February 27-April 1, 2017. This Plan of Correction is the facility's allegation of substantial compliance with Federal and State requirements.	
K 222 SS=D	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is	K222	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standards on 2/27/17 by the Executive Director. a) There is one lock device with one releasing motion to open the exit door from dietary to rear of the building. The Maintenance Director removed the chain lock and dead bolt lock on 2/27/17.	4/15/17

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X5) DATE

Executive Director 3/16/17

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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K 222	Continued From page 1 protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain exit doors. This deficiency affected one of nine smoke compartments. The finding includes:	K 222	How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: 2) a) All facility residents and visitors have the potential to be affected. 100% audit completed by the Maintenance Director of all exit doors to ensure all exits have only one locking device and no further areas of concern were found on 2/27/17. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; 3) a) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standards on 2/27/17 by the Executive Director. The Maintenance Director, and/or the Maintenance Assistants will do audits to monitor compliance weekly for 4 weeks and monthly for 2 months. How the corrective action will be monitored to ensure the deficient practice will not recur; What quality assurance program will be put into place; 4) a) Director of Maintenance will present results of audits to the Performance Improvement Committee. b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business Office	

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K 222	Continued From page 2 Observation and interview with the maintenance director on 2/27/17 at 10:55 AM revealed the exit door from dietary to rear of building required three releasing motions to open. NFPA 101, 19.7.6, 4.6.12 & 7.2.1.5.10.2 The maintenance director was present when the deficiency was identified and was acknowledged by the administrator during the exit conference on 2/27/17.	K 222	Manager, Activities Director, and Staff Development Coordinator will review the results. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	
K 341 SS=D	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure visible notification devices were located in required spaces. This deficiency affected one of nine smoke compartments. The finding includes:	K 341	<u>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</u> 1) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standards on 2/27/17 by the Executive Director. a) Visible notification device was installed in the dining room by the Maintenance Director on 3/2/17. <u>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</u> 2) a)All facility residents and visitors have the potential to be affected. 100% audit completed by the Maintenance Director of all areas required to have visible notification devices and revealed no further areas of concern 2/27/17.	4/15/17

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K 341	Continued From page 3 Observation and interview with the maintenance director on 2/27/17 at 2:30 PM revealed the dining room was not provided with a visible notification device. NFPA 101, 19.7.6, 4.6.12 & NFPA 72, 18.5.4 The maintenance director was present when the deficiency was identified and was acknowledged by the administrator during the exit conference on on 2/27/17.	K 341	What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur: 3) a) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standard 2/27/17 by the Executive Director. The Maintenance Director, and/or the Maintenance Assistants will do audits to monitor compliance weekly for 4 weeks and monthly for 2 months. How the corrective action will be monitored to ensure the deficient practice will not recur; What quality assurance program will be put into place: 4) a) Director of Maintenance will present results of audits to the Performance Improvement Committee. b) The Performance Improvement Committee Consisting of Executive Director, Director of Nursing, Medical Director, Director of Rehabilitation, Director of Health Information, Dietary Manager, Director of Maintenance, Director of Environmental Services, Director of Social Services, Business Office Manager, Activities Director, and Staff Development Coordinator will review the results. If it is deemed necessary by the committee, additional education may be provided, the process evaluated/revised, and/or the audits reviewed for 3 months or until 100% compliance is achieved.	
K 741 SS=D	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is			

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K 741	Continued From page 4 permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain designated smoking areas. The finding includes: Observation and interview with the maintenance director on 2/27/17 at 9:30 AM revealed the smoking area was not provided with a designated metal container with a self-closing lid into which ashtrays can be emptied as required. NFPA 101, 19.7.4 (6) The maintenance director was present when the deficiency was identified and was acknowledged by the administrator during the exit conference on 2/27/17.	K 741	What corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standards on 2/27/17 by the Executive Director. a) A metal container with self-closing cover immediately placed in the designated smoking area by the Maintenance Director on 2/27/17. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 2) a) All facility residents and visitors have the potential to be affected. 100% audit completed by the Maintenance Director to ensure the designated smoking area has a metal container with self-closing cover and revealed no further areas of concern on 2/27/17. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; 3) All facility maintenance personnel were immediately in-serviced on NFPA 101 Life Safety Code Standards on 2/27/17 by the Executive Director. The Maintenance Director, and/or the Maintenance Assistants will do audits to monitor compliance weekly for 4 weeks and monthly for 2 months.	4/15/17

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